Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CRF-000923	A. BUILDING _____ B. WING _____	11/05/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DONNA & SYLVIA THAXTON	938 LONGFELLOW STREET NW WASHINGTON, DC 20011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments A licensure survey was conducted on November 5, 2009. The findings of the survey was based on observations of the Community Residential Facility (CRF), interviews with the administrative staff and residents, as well as a review of clinical and administrative records, including incident reports. A random sample of two residents was selected from a resident population of three residents with various medical disabilities.	D 000	Received 11/10 GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002	
D 600	3403.11 Admission Policies The examining physician shall provide the community residence facility with a written report providing sufficient information on the resident's condition to enable the community residence facility to assist the resident toward rehabilitation, together with a record of any prescriptions, treatment orders, or special instructions for the management and protection of the resident. This CONDITION is not met as evidenced by: Based on interview and record review, the Community Residential Facility (CRF) failed to ensure they received treatment orders and a assessment for one of the three residents (Resident #1) residing in the group home. The findings include: 1. On November 5, 2009, at 1040 a.m., an interview with the director and assistant director and a review of an incident report dated March 29, 2009, revealed Resident #1 was taken to the emergency room for to a behavioral episode. The episode was described as "tearing her room into shambles." Further interview with the directors revealed the	D 600	A unusual Incident Accident form was done and put in her file	3/29/09

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D 600	Continued From page 1 resident was admitted to the hospital and diagnosed with a urinary tract infection and sinusitis. Additionally, while the resident was in the hospital she was prescribed Haldol 0.5 mg. Further interview with the directors and review of the resident's medical record on November 5, 2009, revealed the resident's current annual medical certification was dated April 21, 2009. In addition to the medical certification, the appointment on April 21, 2009 was also a follow-up appointment to the resident's hospital discharge. The Primary Care Physician (PCP) continued the resident on the Haldol 0.5 mg. and increased the Haldol to 1 mg on September 25, 2009. At the time of the survey, the examining physician failed to provide evidence of Resident #1's treatment orders for Haldol. 2. Interview with the assistant director on November 5, 2009, at 3:25 p.m. revealed Resident #1 had a cold in September of 2009. According to the assistant director the resident was taken to her PCP and prescribed Erythromycin ointment and Biaxin XL 50 mg. The assistant director provided Resident #1's Medication Administration Record (MAR) for September 2009. Review of the MAR revealed the aforementioned medication was administered September 1, 2009 through September 18, 2009. At the time of the survey, the CRF failed to provide evidence of treatment orders for Resident #1's Erythromycin and Biaxin. 3. Interview with the group home director's revealed that Resident #1 experienced some sleeplessness and her PCP was contacted in	D 600		

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D 600	Continued From page 2 June 2009. Continued interview revealed the PCP prescribed Trazodone 50 mg at bedtime. At the time of the survey, the CRF failed to provide evidence of treatment orders for Resident #1's Trazodone.	D 600		
D 720	3404.3 Resident Status Policies In cases of serious illness or accident, medical care shall be secured immediately by the resident, if he or she is able, or by the Residence Director who shall first attempt to notify the resident's physician. This CONDITION is not met as evidenced by: Based on interview and record review, the Community Residential Facility (CRF) failed to ensure medical care was secured immediately for one of the two residents (Resident #1) in the sample. The finding includes: Interview with the assistant director and review of the incident reports on November 5, 2009, at approximately 11:15 a.m. revealed Resident #1 had experienced frequent falls. Further review of the incident reports revealed the following falls: June 7, 2009, the resident experienced four falls. June 9, 2009 fell out of her bed. June 16, 2009 fell out of her bed at 9:27 p.m., 11:27 p.m., and at 1:18 a.m. fell out of chair. June 17, 2009 fell in the floor and again at 3:27 a.m. On June 18, 2009, Resident #1 had experienced another fall. She was also experiencing screaming out loud. Review of the record and	D 720	The Residents Doctor was Contact on 11/5/09 about needing a Referral and a Referral was giving to us on 11/17/09 but Dr is no longer taking new Clients so we have called and called to get another Reffer, We have now ask her niece to ass us with getting a Referral from her Dr.	Not Complete

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D 720	Continued From page 3 interview with the assistant director revealed the resident had not slept for days. According to the director, the PCP was contacted regarding the resident's behavior and prescribed Trazodone 50 mg. At the time of the survey, the facility failed to ensure immediate medical care was secured for Resident #1.	D 720		
D3000	3421.1 Housekeeping and Laundry Services The interior and exterior of each community residence facility shall be maintained in a safe, clean, orderly, attractive, and sanitary manner free from accumulations of dirt, rubbish, and objectionable odors. This CONDITION is not met as evidenced by: Based on observation and interview, the Community Residential Facility (CRF) failed to maintain the interior of the facility in a safe, clean, orderly, and attractive manner. The findings include: On November 5, 2009, an environmental inspection was conducted noting the following environmental concerns: 1. The resident ' s food inside the kitchen refrigerator was not labeled. Several food items were not in the original packaging. 2. The kitchen pots and pans evidenced excessive grease. 3. The kitchen floor tiles were broken posing a potential trip risk.	D3000	1. We have Label and date all prepared food in the Refrigerator that are not in original packing. 2. they have been clean of grease 3. Floor tiles have been Replace	11/6/09 11/6/09 11/15/09

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D3000	Continued From page 4 4. Bathroom cabinet under the sink needs cleaning. 5. The sky light in the bathroom ceiling needs cleaning. 6 The right rear bedroom had a hole in the wall. At the time of the environmental inspection, the facility Director acknowledged these deficiencies.	D3000	4. Cabinet in the bathroom under my sink has been clean and painted 5. the sky light in bathroom has been clean and we will every two month have it clean. 6. the hole in the wall has Repaired and closed up	11/12/09 11/16/09 11/16/09